NAME: BOB CORONA
ADDRESS:
456 BASKET DRIVE
ADOMINO, NY 12347

MRN#: 238-12-3456

ACCT#: 11223377
DOB: 11/01/1935

SSN# 999-99-9993

RACE: U

SEX: M
RELIGION: BAPT
MARITAL STATUS: W

MANAGING MD: DR. O. SIGMOID
DIAGNOSIS: C153.9
PATIENT PHONE# 555-222-1115

EMPLOYER: NOT STATED

EMPLOYER ADDRESS: NOT STATED

INSURANCE PROVIDER: BC/BS NY
GROUP #: ABC1235

ADMIT DATE: 07/28/2005

HISTORY & PHYSICAL

CHIEF COMPLAINT: History of carcinoma of the colon.

PRESENT ILLNESS: This 71-year-old is referred after having had a colon resection seven years ago for colon carcinoma. Six years ago he had a colonoscopy and polyps removed. The patient is being admitted at this time for repeat colonoscopy on 7/28.

PAST HISTORY: Had colon resection for carcinoma of the colon, otherwise, negative.

Current Medications: Tenormin

REVIEW OF SYSTEMS: Wears glasses, but no history of any other serious illnesses.

PHYSICAL EXAMINATION:
Vital Signs: BP 130/80, P 80, T 98.6, RR 18.
HEENT: No abnormalities noted.
Neck: Supple. Thyroid not palpable.
Lungs: Clear to auscultation and percussion.
Heart: Normal sinus rhythm. No murmurs. No cardiomegaly.
Abdomen: Soft. Liver, kidneys and spleen not palpable. Normal bowel sounds.
Extremities: No abnormalities noted.
Genitalia: No abnormalities noted.
Rectal: Normal.
Neurologic: Physiologic.
Lymph Nodes: Not palpable.

IMPRESSION: Past history of colon carcinoma.

PROCEDURE DATE: 07/28/2005

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Carcinoma of the splenic flexure of the colon, postop colon resection for sigmoid carcinoma

POSTOPERATIVE DIAGNOSIS: (none given)

PROCEDURE: Exploratory laparotomy, colon resection, splenectomy

PROCEDURE IN DETAIL: The patient was placed in the supine position. After adequate endotracheal anesthesia, a midline incision was opened down the peritoneal cavity. The patient was found to have carcinoma of the splenic flexure, which was adhered to surrounding structures in the left upper quadrant. Dissection was carried out with the transverse colon which was cut through with the GIA. The omentum was removed from the left transverse colon. This was followed up to the left upper quadrant. Following this, at the mid descending colon, a transaction of the descending colon was done with the GIA. The mesentery along with the left colon in this area was removed entirely with the use of Ligasure. On entering the left upper quadrant, there were some inflammatory changes around the tumor site, which was excised. In the process, the spleen began to bleed. Attempts at repairing the spleen with FloSeal and other treatment modalities including Surgicel were unsuccessful. Therefore an incidental splenectomy was performed. The spleen was brought forward and the splenic vessels and its vascular were doubly ligated and divided, followed by ligation of the short gastric vessels. After adequate hemostasis, a #19 drain was placed in the left upper quadrant and brought out through a separate stab incision on the left side of the abdomen. After adequate hemostasis, a side-to-side anastomosis was then done with the remaining colon using he GIA followed by the TA-65. The anastomosis appeared to be well with good blood supply. The remainder of the abdomen was explored. No other abnormalities were noted. The wound was then closed in layers with loop PDS suture and retention sutures. The patient tolerated the procedure well and was sent to recovery in good condition.

PROCEDURE DATE: 07/28/2005

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Recurrent colon cancer

POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: Cystoscopy with placement of bilateral ureteral catheters, 5 French whistle-tips

COMPLICATIONS: None

INDICATIONS FOR PROCEDURE: The patient is a 71-year-old male with history of recurrent colon cancer here for colon resection. He presents for preoperative ureteral catheters.

PROCEDURE IN DETAIL: The patient was prepped and draped in standard surgical fashion in the dorsal lithotomy position. After induction of general anesthesia and IV antibiotics, the #22 French sheath with 12 degree lens was used to negotiate his urethra. He did have anterior ureteral strictures through his penile and membranous urethra. They were of large caliber and very soft and easily accommodated a #22 French scope. After we negotiated the anterior urethra, the prostate was negotiated and the bladder was entered. Both ureteral orifices were in their normal anatomic position and inspection of the bladder did not show any papillary masses or other abnormalities. After inspection, the 5 French whistle-tip catheter was used to negotiate his right ureteral orifice and under fluoroscopy, confirmed it was in place in the renal pelvis. The scope was withdrawn and the catheter advanced and then the scope was reinserted alongside the catheter and the left ureteral catheter was placed. Both went up without difficulty and both were confirmed in placement with fluoroscopy. The patient tolerated the procedure well and went to his colon resection in stable condition.

PROCEDURE DATE: 07/28/2005

PATHOLOGY REPORT

SPECIMEN SUBMITTED:
A. Colon, segmental resection for tumor
B. Spleen

CLINICAL HISTORY: None given
PRE-OP DIAGNOSIS: Colon CA
POST-OP DIAGNOSIS: None given

GROSS EXAMINATION:
A. Received unopened in formalin is a 14 cm segment of colon measuring about 2.5 to 3 cm in diameter. Close to the center of the specimen is a tumor measuring 4 x 4 cm and up to 8 mm in thickness. The tumor has rolled margins. The tumor is 3 cm from the closer bowel margin. A cross section of the closer margin is submitted in cassette 1 and of the more distal margin (which is 7 cm from the tumor) in cassette 2. An area of ulceration is noted near this margin measuring 9 mm in diameter: sections are submitted in cassette 3. Half a dozen small lymph nodes are bivalved and submitted in cassettes 4 and 5. Cut section shows that the tumor has extended through the muscular wall and has produced some kinking of the bowel. Cross sections of the tumor are submitted in cassettes 6, 7 and 8.
B. Received in two pieces of the spleen weighing 142 grams and measuring 11 x 7 x 2.5 cm. A blood-filled bleb measuring 2 x 1 cm is noted on the surface but may be artifactual. Cut section is unremarkable. Representative sections are submitted in cassettes 1 and 2.

MICROSCOPIC EXAMINATION:
A. Sections demonstrate a moderately differentiated adenocarcinoma extending through the muscularis propria and just into the pericolic adipose tissue. The margins are negative for tumor. The seven regional lymph nodes are negative for metastatic tumor. The ulcer near to the more distant surgical margin shows mucosal ulceration, an area of full-thickness necrosis, and a thin layer of fibrinopurulent serosal exudate. The exudate is also seen on the surgical margin cross-section.
B. Sections demonstrate a benign spleen with an area of fresh subcapsular hemorrhage, apparently artifactual.

DIAGNOSIS:
A. Segmental resection of colon: Moderately differentiated adenocarcinoma extending through the muscularis propria and into the pericolic adipose tissue; surgical margins, negative for tumor; seven regional lymph nodes, negative for metastatic tumor; localized area of transmural necrosis and localized fibrinopurulent exudate near one margin of resection
B. Splenectomy: Benign 142 gram spleen.

MEMORIAL HOSPITAL - PATIENT IDENTIFICATION Acsn # |_____/_____|

|_____Corona_____Bob_____|_____|_____|_____|
Patient Last Name **First Name** **MI** Prefix Suffix

|_____| |_999__ - _99_ - _9993___| |__238-12-3456_____|
Maiden Name/Alias SocSec# MR #

Address |_____456 Basket Drive_____| **County** |_____|

City/**St**|_Adomino_____|__NY_| Zip + 4|_12347_|_____| Area Code/Phone #|_555/_222_-_1115_|

PT PERSONAL INFO **Birthdate** |_11__/_01__/_1935___| **Age**|_71_____| **Birth Loc** |__999___|

Sex |_1__| **Race** |_99__| **Hisp Orig** |_9__| **Race#2-5** |_88_| |_88_| |_88_| |_88_| **Insurance** |___10_____|

Spouse Last Name/First Name |_____|_____|

Occup |_____| Indus|_____|

Comments

SECONDARY CONTACT Phone |_____/_____-_____| Relation |_____|

|_____| |_____| |____|
Last Name First Name MI

Address |_____|

City|_____| St|_____| Zip+4|_____|_____|

DIAGNOSIS IDENTIFICATION **Seq #** |_00___|

Site |_____Colon Splenic Flexure_____| Site code |___C185_____|

Histology |_____Adenocarcinoma_____| Hist code |___8140_____|

Behavior |___3___| **Grade** |__2__| Coding Sys Site |ccc| Morph |ccc| Conv flag |ccc|

Laterality |_0_| **Dx Confirm** |_1__| **Rpt Src** |_8__| Casef Src |_20__| Class/Case |_1__|

Supporting Text 7/28/05-Segmental resection-4 x 4cm md adenoca ext thru the muscularis propria and into pericolic adipose tissue. Margins neg. seven regional LNS neg. Splenectomy neg.

DATE INIT DX |_07_/_28_/_2005| Admit |____/____/____| D/C |____/____/____|

DX EXT OF DIS CS Tumor Sz (mm) |_040__| **CS Extension |_45__|** CS T Eval |_____|

#LN exam |_____| #LN + |_____| **CS LN |_00__|** CS N Eval |_____|

CS Ver 1st |_____| CS Ver Latest |_____| **CS Mets |_00__|** CS M Eval |_____|

CS SS Factors #1 |_____| C38.4 only #2 |_____| **#3** |_____| C619 only #4 |_____| #5 |_____| #6 |_____|

Sum Stage |__1__| Version |ccc| Derived |ccc|

pT |_____| N |_____| M |____| Stage |_____| Descrip |___| Staged By |____| **AJCC Ed** |ccc|

cT |_____| N |_____| M |____| Stage |_____| Descrip |___| Staged By |____|

Staging Descrip _____

Date First Course of Treatment |__07__/_28___/_2005__| Date Init Rx |__07__/__28__/_2005__|

Surgery

Date|07__/_28_/2005| Surg Prim Site |_30____| Scope LN |_5_| Other|_4__| Reason No Surg |_0__|

Date|____/____/____| Surg Prim Site |_____| Scope LN |_____| Other|_____| Reason No Surg |_____|

Date|____/____/____| Surg Prim Site |_____| Scope LN |_____| Other|_____| Reason No Surg |_____|

OTHER TREATMENT

Date |____/____/____| Radiation Sum |_____| Surg/Rad Seq |_____| Reg Rad Rx Modal |_____|

Date |____/____/____| Chemotherapy Sum |___|

Date |____/____/____| Hormone Sum |___|

Date |____/____/____| BRM Sum |___| Other Rx Sum |___| Transpl/Endocr Sum |___|

PHYS SEQ
N = _____

M = _____ Ref From _____

R = _____ Add _____

F = _____ Ref To _____

2 = _____ Add _____

3 = _____ Comments: _____

PT STATUS Date Last Contact |_07__/_28__/2005_| Vital Stat |_1__| CA Status |_1__| FU Source |__0|

COD (ICD) |_____| ICD Revision |_____|

OVERRIDE FLAGS

Age/Site/Morph |ccc| SeqNo/Dx Conf |ccc| Site/Lat/SeqNo |ccc| Site/Type |ccc| Histol |ccc|

Rept Source |ccc| Ill-def Site |ccc| Leuk,Lymph |ccc| Site/Beh |ccc| Site/Lat/Morph |ccc|

Additional Data

Census Tract |ccc| Cen Cod Sys |ccc| Cen Year |ccc| Cen Tr Cert |ccc|

NHIA Hisp Orig |ccc| IHS link |ccc| Comp Ethn |ccc| Comp Ethn Src |ccc|

Rec Type |ccc| Unique Pt ID |ccc| Reg ID |ccc| NAACCR Rec Ver |ccc|

KEY Data items in **Bold** are required fields Other data items are optional or “advanced surveillance” |ccc| computed field, no manual input Shaded are optional non-NPCR items